Staff Injury Report

Date of Incident: _____ **Time of Incident:** _____

Location of Incident: _____

Details of Injured Person:

Name: _____ **Residential Address:** _____

D.O.B: _____ _____

Basis of Employment of Staff: ☐ Full Time ☐ Part Time ☐ Casual

Type of Incident:

☐ Client Injury ☐ Staff Injury ☐ Serious Bodily Injury

☐ Work Caused Illness ☐ Dangerous Event/Near Miss ☐ Vehicle

Verbal Report Made: ☐ **Date Reported:** _____

Name of Person Reported to: _____

Date Written Report Completed: _____

Checklist:

☐ Have I contacted the Office/On-Call?

☐ Have I followed all of the supervisor's recommendations?

☐ Have I filled out all of the form?

☐ Have I submitted the Report?

Staff Name: _____ **Signature:** _____ **Date:** _____

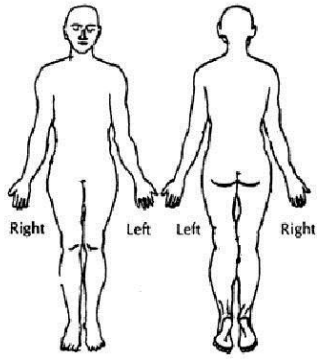
Witness to Incident Name: _____ **Signature:** _____ **Date:** _____

Nature of Injury/Illness: *e.g. Fracture, strain, burn, etc.*

_____

_____

Bodily Location of Injury/Illness: *Please list below and indicate on diagram*



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Medical Treatment: ☐ Nil ☐ First Aid ☐ Doctor Only ☐ Ambulance ☐ Hospital

Mechanism of Incident:

☐ Fall/Trip/Slip ☐ Biological ☐ Mental Stress ☐ Chemicals

☐ Heat/Electrical ☐ Body Stress/Pressure ☐ Behavioural ☐ Vehicle

☐ Other: _____

Details of Incident:

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If additional sheets are required please attach.

Version 1	
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